

PROVIDENCE HEALTH CARE (PHC) PROGRESS IN IMPLEMENTING RECOMMENDATIONS FROM

Infection Control: Essential for a Healthy British Columbia

As at July 31, 2009

General comments

Timeline:

- 27Mar08 - PHC submitted a response to recommendations with a self-assessed status of either “full” or “substantial”.
- 02Jul08 - PHC submitted a further report to satisfy the Auditor General’s request for additional information.
- 23Sep09 - Discussions with the Office of the Auditor General indicated that a further PHC response and report was not necessary because PHC had fully or substantially implemented all recommendations. However, PHC was informed that the Auditor General would be interested in further progress PHC has accomplished for any recommendation since 02Jul08.
- 30Sep09 - Highlighted examples of PHC “further progress” are provided in the below table (e.g. recommendations #1, 4, &18). These examples were selected because of the current importance of planning and collaboration.
- 30Sep09 - PHC has also contributed to the provision of the overall VCH progress report.

Since February 2009, VCH, FH and PHC have been formally collaborating in the development of a work plan to standardize many components of Infection Prevention and Control (IPAC) across the Lower Mainland. The initiative is led by a steering committee composed of executive leaders, and key stakeholders (including Public Health) from the three health authorities. PHSA has recently joined this collaboration.

This initiative includes sharing of material and information resources. Key areas of collaboration include:

- Hand hygiene
- Environmental cleaning
- Outbreak Management
- Surveillance
- High priority interventions and surveillance for:
 - MRSA, VRE, & CDAD - Implement a series of evidence-based guidelines to prevent harm.
 - CLI - Central Line-Associated Bloodstream Infection: Prevent central venous catheter-related bloodstream infection (CR-BSI) and deaths from CR-BSI by implementing a set of evidence-based interventions in all patients requiring a central line.
 - SSI - Surgical Site Infection: Prevent surgical site infection (SSI) and deaths from SSI by implementing a set of evidence-based interventions in all surgical patients.
 - VAP - Ventilator-Associated Pneumonia: Prevent ventilator-associated pneumonia (VAP) and deaths from VAP and other complications in patients on ventilators by implementing a set of interventions known as the "VAP bundle."
- IPAC education for all staff and physicians
- Policies and procedures (including IPAC manual)
- Precaution Standards

Status F or S – Recommendation has been fully or substantially implemented
P – Recommendation has been partially implemented
AA – Alternative action has been undertaken, general intent of alternative action will addresses OAG finding
NA – No substantial action has be taken to address this recommendation

- Communication, reporting, and behavioural change campaigns
- Construction/facility design
- Education and professional development for Infection Control Practitioners (ICPs)
- Staff education
- Accreditation

Additionally, provincial IPAC directors/leaders hold a monthly teleconference to share ideas and resource materials. We are hopeful that the above active collaborations will result in more shared resources and greater use of our expertise.

PHC Further Progress Highlights - Recommendations #1, 4, and 18

Self-Assessed Status	Actions Taken Since Report Issued	Results of Actions and/or Actions Planned (with information on implementation, including dates)
Recommendation 1: Each health authority develop an integrated plan for infection prevention, surveillance and control across the continuum of care.		
F	<p>PHC Infection Control and Prevention (IPAC) has developed integrated strategic plans in</p> <ul style="list-style-type: none"> ▪ 2005 (previous submitted) ▪ 2008 update (<i>Appendix A</i>) ▪ 2009 – 2012 draft update (<i>Appendix B</i>) <p>The latter IPAC plan is organized to reflect the elements of a best practice infection control program. These same elements will be used for lower mainland collaborative planning.</p> <p>IPAC support is provided for all PHC clinical programs and departments (including inpatients, outpatients, and residents). Equity is addressed by using an allocation model (<i>Appendix C</i>) to assign responsibilities to Infection Control Practitioners (ICPs). Acute and Residential Care assignments are based on ICPs per bed (see Recommendation #4). Outpatient areas receive ICP allocated support based on labour budget magnitude.</p> <p>PHC, VCH, and FHA have worked collaboratively in 2009/10 to develop a draft work plan to capture economies of scale and to avoid future cost increases for the Lower Mainland. (see <i>Appendix D</i>)</p>	<i>Appendix A, B, C, D</i>

Status

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Recommendation 4: Each health authority undertake a formal review to estimate their overall requirements for both Infection Control Practitioners and Communicable Disease Nurses, giving consideration to: ratios; needs of other programs such as home and community care, residential care and mental health; and to the educational needs of staff. They should also ensure adequate medical and clerical support for the program.

<p>F</p>	<p>Compared with best practice recommendations, PHC has an ICP budget which is insufficient in terms of ICPs per bed (<i>Appendix E</i>).</p> <p>Considering the current economic climate, PHC has started a front line Link Nurse program to help care providers adopt and sustain IPAC best practices (see IPAC Link Nurse role description – <i>Appendix F</i>). A group of IPAC Link Nurses (approximately 30) have recently received 1 day of training to kick-off their important role.</p> <p><i>Appendix G</i> provides the results of a recent IPAC educational needs survey.</p>	<p><i>Appendix E, F, G</i></p>
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Recommendation 18: Each health authority Board of Directors hold the Medical Advisory Committees accountable for fulfilling their mandates.-+

<p>F</p>	<p>PHC has developed a Hand Hygiene e-learning module, designed specifically for physicians. Medical staff must complete this module every two years as a condition of re-appointment. VCH, BCCA, and BCCH physicians also use this e-learning module (FHA will soon be).</p>	<p>Web link to this module is:</p> <p>http://www.phcipac.ca</p>
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Actions	Lead Members	Start Date	Completion Date	Status
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Infection Prevention and Control (IPAC) STRATEGIC PLAN

Apr-05 to Mar-09

Consistent with, and in the context of, the Values and Mission of Providence Health Care...

The **Vision** of the Infection Control Team is to create and sustain a culture in which infection control is integrated into all aspects of care. The **Mission** of the Infection Control Team is to be dedicated to the prevention and control of health care acquired infections in a supportive working environment. The practices of the Infection Control Team will be based on sound scientific principles. Infection control services will be provided to Providence Health Care with structure and authority in collaboration with local, regional and provincial partners.

IPAC Team Members

Name	Title
Marc Romney MD, FRCPC, DTM&H	Medical Director, IPAC & Medical Microbiologist
Howard Green B.Sc. M.B.A.	Team Leader, IPAC
Mark Hull MD, FRCPC	Physician, Acute Care, IPAC
Debbie Jacobson MD, CCFP	Physician, Residential, IPAC
Jayne Bradbury B.Sc. M.P.A.	Epidemiologist
Jim Curtin RN, BSN, CIC	ICP
Mary McNaughton RN, BSN, MSA, CIC	ICP
Craig Pienkowski RN, BN, BSc	ICP
Stuart Gray RN, MSc, DLSHTM	ICP
Wayne Gilbert RN, BSc (Hons)	ICP
Azra Sharma RT B.Sc. M.Sc.	ICP
Christopher Sherlock MD, FRCPC	Medical Microbiologist
Sylvie Champagne MD, FRCPC	Medical Microbiologist
Luz Vierneza	Clerk

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Strategic Direction 1: Achieve Exceptional Care, Service, Teaching and Research				
Measures:				
1. Determine the level of infection control knowledge by way of a written, random survey administered across Providence Health Care (PHC).			Feb-09 Complete as a component of Champion's project	Knowledge survey was done in April 2007 before the ICC project was started. Compared IPAC Champions ward vs. control wards.
2. Increase surveillance across PHC.	Epidemiologist		Mar-09	Based on the model to add one major system per year, completed to date are new databases and reports for: <ul style="list-style-type: none"> • MRSA • VRE • <i>C. difficile</i> • AROs in Hemodialysis Additionally systems are in place for outbreak investigations and reporting. ARO and CDAD systems were refined. A system for regular data cleaning and development of data dictionaries has been implemented. Data validation (through evaluation of screening completeness) has also been a priority.
3. Identify trends in hand hygiene compliance at selected PHC sites. Develop ongoing hand hygiene monitoring & reporting system.	J. Bradbury		Complete	"Clean hands for life" (CHFL) campaign (including observational compliance audits) has been actively in place since 2005. Hand hygiene audits were completed to evaluate baseline and the introduced phases of the CHFL campaign. Additional audits were completed as part of the Infection Control Champions (ICC) project. Results have been provided in the IPAC annual report. Quarterly hand hygiene audits were introduced in the third quarter of fiscal 2008-2009.

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Objective 1.1				
Develop an appropriate structure integrating Infection Control (IC) across all of PHC. The structure will address leadership, authority, resources, and budget.			Mar-09	Organizational structure complete. IPAC now has its own cost centre, budget, and accountability. Regular rounds for SPH and MSJ are occurring weekly. Opportunities for improvement: <ul style="list-style-type: none"> • assign ICPs to units and sites (completed). • complete consistent, ongoing rounds in all PHC residential sites.
1.1.1 Incorporate successful strategies and structures from VRE Control group. Explore and implement ways to ensure the program is sustained.	Dr. Sherlock, ICPs	Apr-05	Complete	VRE enhanced cleaning team in place (5 FTE at SPH), 1 FTE at MSJ), which are assigned by the IPAC ICPs. VRE fact sheets are published on the IPAC web site.
1.1.2 Form a structure that incorporates IPAC Team, and Outbreak Management Team. Define the role, responsibilities, and relationships between IPAC Team and Emergency Preparedness (EP).	Dr. Sherlock	Apr-05	Complete	For all outbreaks, IPAC consults and coordinates with EP.
1.1.3 Clarify roles, reporting, and authority relationships of the Infection Control Committee and the IPAC Team.	ICPs, Dr. Romney, Dr. Sherlock	May-05	Nov-05 Jan-09	Consultants report completed and implemented: "A Review of Organizational Parameters for the PHC IPAC Service". ICPs assigned equitably to dedicated nursing units based on Quebec model, "# of ICPs per bed"
1.1.4 Define the role and responsibilities of, identify and train IC "Champions" (ICCs).	Dr. Romney, Dr. Sherlock		Intervention phase completed 25Jun08	Analysis phase is now underway. Also looking for funding support to continue the ICC project
1.1.5 Determine authority required for Infection Control Committee and the IC Team.	Dr. Romney, Dr. Sherlock	Apr-05	Complete	IPAC reports to MAC and VP Medical Affairs.
1.1.6 Establish a cost centre and budget for the IC Team.	Dr. Sherlock, Dr. Romney, Dr. Mithani	Apr-05	Complete	
1.1.7 Explore and implement ways to ensure the ICC program is maintained.		2006/07	Mar-09	For ICC project, focus groups were held for all participants. All focus group members reported a positive experience with the trial phase of ICCs. Ideas to make ICCs an ongoing program were obtained from all stakeholders:

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				<ul style="list-style-type: none"> - Operations Leaders - ICCs - IPAC team members - Front line staff
Objective 1.2:				
Establish and advance surveillance systems for selected nosocomial infections.	Epidemiologist	2007/08	Complete	Epidemiologist has developed surveillance system for norovirus and influenza outbreaks, which included epicurve, line list, date of onset, and daily status report.
1.2.1 Determine the nosocomial infections for which surveillance will be performed. Assemble list and distribute to IC Team.	Jayne Bradbury	Apr-05	Jun-08	As of June 08, 2008 we have enhanced surveillance systems for MRSA, VRE, CDAD, and TB. Surveillance systems in progress include BSI, SSI, and VAP.
1.2.2 Advocate for appropriate levels of clerical support needed for surveillance initiatives.	Dr. Sherlock. Dr. Romney	Apr-05	Complete	Full time infection control clerk hired as 1.0 FTE IPAC support. Unique Cost Centre was established for IPAC.
1.2.3 Establish a surgical site infection surveillance system with a goal of monitoring and reducing surgical site infection rates.	Epidemiologist	May-05	Mar-09 for Arthroplasties Apr-09 for Caesarean sections	SSI program for arthroplasties started but administrative changes resulted in some delays in full implementation. Surveillance now performed on C-sections. Program to be expanded to other high-risk surgical categories. System to collect post-discharge infections in progress.
1.2.4 Establish a catheter-related bloodstream infection surveillance system.	Epidemiologist	Jun-05	Dec-07 completed but lab system changed	Dec 2007 – developed an electronic surveillance system for BSI in the ICU that extracted data from the old lab system. June 2008 – Lab system changed; existing surveillance system no longer functional. A semi-automated surveillance system is now being used until software revisions are obtained (see IPAC plan 2009 – 2012).
1.2.5 Refine the surveillance systems for AROs.	Epidemiologist	Summer 2005	Mar-09	<p>Aug 07 - developed <i>C. difficile</i> surveillance system with a revision to the database</p> <p>Dec 07 - "Care Connect" used to review ARO alerts in VCH network.</p> <p>April 08 - using the new MRSA and VRE Access data base, a new ARO report was developed.</p> <p>Apr-08 analysis and CDAD reporting completed</p> <p>May 08 - using "Sunset" to get direct access to microbiology results.</p> <p>December 08 – data cleaned every fiscal period; regular review of issues with certain fields with ICP.</p> <p>February 09 – minor revisions to the ARO form</p>

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				(improvements and AMP changeover) March 09 – Development of data dictionaries to assist with accurate form completion.
1.2.6 Refine the surveillance systems for TB.	Epidemiologist	Sep-05	Complete	March 07 - revision to the TB report form and addition of the new CDC and HC TB guidelines
1.2.7 Refine the surveillance systems for outbreaks of influenza, norovirus, etc.	Epidemiologist	Oct-05	Complete	Feb 08 - Norovirus molecular testing introduced, which reduced virus ID time from 5 days to <24 hours. [Molecular testing for influenza now available on site.] Outbreak databases and reports completed. Epi curves developed for both gastrointestinal and respiratory outbreaks. Access database created to track outbreak summary data. Nov 07 - Influenza outbreak guidelines revised by Dr Jacobson.
1.2.9 Evaluate compliance with IC standards e.g. screening tool.	Jayne Bradbury	May-05	Feb-09	Nov08 - ARO screening tool is now included in doctors admitting orders. Feb09 – preliminary audit of screening tools done. Future audit methods to be developed.
1.2.10 Advocate for resources for establishing and refining surveillance systems at PHC.	Jayne Bradbury	Nov-05	Jan-09	Care Connect, Sunrise Clinical Manager, Access data bases for AROs, Access Databases for flu and norovirus outbreaks. Screening compliance rates are being monitored.
1.2.11 Advocate for adequate information technology to support surveillance initiatives.	Jayne Bradbury	Dec-05	Jan-09	Ongoing. Department worked with IMIS to ensure the implementation of Access manager produced new surveillance reports.
Objective 1.3:				
Control and manage outbreaks of infectious disease at PHC.				
1.3.1 Develop a outbreak management plan (includes issues relating to supplies, communications, authority, etc.) for:	ICPs	Jun-05	Complete	The Influenza Outbreak Protocol is on the IPAC website and is reviewed frequently and revised when best practice changes are required. The protocol is simplified to reflect the very specific duties of staff during an outbreak. Influenza outbreak in-services are regularly provided to all

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<ul style="list-style-type: none"> Influenza Norovirus 				PHC residential care staff. Norovirus outbreak plan is also posted on the IPAC web site and in-service education was provided for the 07/08 season.
Objective 1.4:				
Practices of infection control are integrated into the work of all staff, physicians & contracted services.				
1.4.1 Develop and implement an education strategy for physicians in collaboration with the Physician Leader, Medical Education. Identify physician role models for their support and compliance with IPAC policies and procedures.	Dr. Romney Dr. Hull Dr. Jacobson	Mar-06	Dec-08	Online Physician Hand Hygiene Module developed and implemented. Weekly IPAC rounds are ongoing.
1.4.2 Develop, implement, and monitor an education plan for PHC staff.	IPAC Team	Sep-5	Complete & Ongoing	IPAC educational plan includes huddle new staff orientation, PEP days, Physician On-Line Hand Hygiene e-learning module, fact sheets, ED days, unit specific in-services etc. E-learning modules continue to be developed and links to permitted e-learning websites are provided to staff on the intranet website.
1.4.3 Promote the use of the on-line IC manual.	Jim		Jan-06	The IPAC on-line manual was first published 2003 and web published in 2006. Staff have been trained to revise the website and manual.
1.4.4 Collaborate in the development of IC standards for monitoring contracted services.	J. Curtin & M. McNaughton		Dec-07	On going work with Aramark, Paladin and Sodexho.
Objective 1.5:				
Expand the delivery of IC education.				
1.5.1 Collaborate in the development and implementation of an education program for patients and visitors.	ICPs	2006/07	Aug-08 & Ongoing	May-08 Developed hygiene recommendations for patients & visitors. Nov-08 - MRSA brochure updated. Aug-08 CHFL project which uses "Talking Walls" signage has been designed to engage both staff and visitors .(signs are regularly rotated to refresh messages)
Objective 1.6:				

Actions	Lead Members	Start Date	Completion Date	Status
Provide effective IC coverage to all PHC sites according to Health Canada standards.	Dr. Romney		Jan-08 & Ongoing	Sept 07 Instituted IPAC rounds at SPH site Jan 08 IPAC rounds at MSJ site. Residential rounds have not been developed.
1.6.1 Advocate for adequate resources and personnel to ensure initiatives from IC Team Strategic Plan are acted upon.	Dr. Romney	Ongoing	Dec-09	Ongoing. From a HR perspective we have increased our ranks with qualified IPAC physician, ICP, Epidemiologist and clerical support. IPAC space issues have been addressed with the renovation of office spaces and the addition of 2 new offices for physician, admin and ICP. In 2008 a BCNU position was converted to HSA. IPAC team has now hired to the full budget of 6.0 FTE. This number is still below recommended Canadian guidelines.
1.6.2 Broaden hours of coverage for ICPs.	Dr. Romney	Apr-05	Jun-05	June 05 working ICP coverage from approximately 0730-08 to 1700. Med Micro on call from 1700 to 0800 and on weekends and stat holidays.
Goal 2: Create an environment that attracts and retains the best people.				
Measure:				
All staff have access to at least one educational opportunity per year.				
Objective 2.1:				
IC Team stays current with standards and best practice.				
2.1.1 Review current journals, re-assess and purchase alternatives if necessary (begin with an inventory).	Dr. Romney, H. Green		Complete	To save costs, we have reduced hard copy journals to: <ul style="list-style-type: none"> • CHICA Journal (free) • ICHE All IPAC team members have access to a wealth of references from the UBC Library.

Actions	Lead Members	Start Date	Completion Date	Status
2.1.2 Update IC textbooks.	IC Team		Dec-06	2006 new APIC text and 3rd edition of Mayhall Hospital Epi and IC
2.1.3 Advocate for staff to have access to at least 1 educational opportunity per year.	Dr. Romney, Dr. Sherlock		Mar-08	Funding has and is available for staff to attend IC conferences if they will be presenting papers, posters and oral work. Some grant funding is allocated to research presentations at conferences.
Objective 2.2:				
Encourage participation in national, provincial, and regional IC organizations.	IC Team			Mary is on the CHICA BC executive for 2006 to 2008. Mary on CHICA nation executive from 2002 to 2004 Jim on CHICA BC executive from 2002 to 2005. Gayle, Renée, Jayne and Dr. Champagne provided support to the PICNet CDAD surveillance. Jim has supported ARO guideline development. Drs. Romney and Champagne are members of the PICNet BC advisory committee. The department applies for international awards (e.g. Oxoid award for excellence in infection control).
2.2.1 Develop a recruitment strategy emphasizing our strengths to attract talent	H. Green		Jan-09	Recruiting for part-time IPAC physician to replace Dr. Mark Hull.
2.2.2 Develop and deliver training on research methodology for IC staff.	J. Bradbury		Mar-07 & ongoing	Monthly ICP educational rounds are required, with Jayne providing most of the education. ICPs if they have attended a conference, will share their new knowledge in this forum.
Goal 3: Support research and new knowledge integration.				
Measure:				

Actions	Lead Members	Start Date	Completion Date	Status
Continually increase the number of abstracts, grants submitted, and articles published or presented by the IC Team.				2008 Abstract to the Canadian Association of Nephrology Nurses and Technologists accepted for managing patient with an ARO in CDUs. CIHR grant (2007 – 2010) Clean Hands for Life grant from Bayer Canada (2006, 2007, 2008, and 2009)
Objective 3.1:				
Disseminate learning from research findings at PHC.				
3.1.1 Develop a plan to disseminate lessons learned from research.	Epidemiologist		Feb-07	Plan complete.
Objective 3.2:				
Ensure continuing education of IC Champions.	IC Team		Jun-08	2006 ICC planning and content development, June 2007 start the ICC projects with ICC units and control units. 12 work shops, projects and units audits completed. The intervention phase was completed in June 2008. To continue with the provision of education, a two-way link between “Research ICCs” and the IPAC department is being maintained.
Objective 3.3:				
Conduct research to support the integration of evidence-based practices into daily practice.				Ongoing.
3.3.1 Identify areas of research focus and prioritize.	Dr. Romney Epidemiologist		Mar-07	<ul style="list-style-type: none"> • Infection Control Champions • Hand hygiene
Goal 4: Achieve strategic growth.				

Actions	Lead Members	Start Date	Completion Date	Status
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Objective 4.1:				
Participate in the design of the Legacy Project and Campus of Care regarding infection control issues.				
4.1.1 Maintain and promote current relationship with Legacy Project architect and planners, and enhance relationship with those involved with the establishment of the Campus of Care.	Dr. Sherlock, Dr. Romney		MSJ Transformation, Campuses of Care is not currently in an active planning stage.	IPAC Team representation on the Legacy Project (SPH Renewal, MSJ Transformation, and Campuses of Care) Renewal Project is maintained or enhanced. 2006 - initial meeting with the design team to discuss the IPAC evidence for construction, HVAC, room placement for a new hospital. Essential for future planning: <ul style="list-style-type: none"> • 1 patient • 1 room • 1 bathroom
Objective 4.2:				
Ensure IC Team participation in expansion of PHC programs.				
4.2.1 Program Directors and Planning Department must be informed of the requirement to involve IC Team in program expansion projects.	Dr. Sherlock		Jun-05	Have maintained a relationship with PHC planning, OH&S (e.g., implementation of dust control plan) for all new construction and renovation projects. An improved communication process amongst stakeholders has helped to approve final plans and last minute changes.
Objective 4.3:				
Play a leadership role in the design and implementation of a Regional IC Strategy.				PHC participates in the VCH Regional Infection Control Committee (RICC).

Actions	Lead Members	Start Date	Completion Date	Status
4.3.1 Advocate to improve the effectiveness of regional contact tracing and flagging systems (Regional relationships).	J. Bradbury		Mar-09	IPAC now using "Care Connect" program to view IC alerts in the VCH region. "Sunset" is used to view the VCH Misys/Sunquest Lab results for all VCH.
4.3.2 Review contact tracing process within PHC, particularly for TB exposure.	J. Bradbury, M. McNaughton		Dec-08	Contact tracing process is continually reviewed and improved upon. During the implementation of new admitting software (Access Manager) the process was revised in Dec08.
4.3.3 Promote evidence-based IC practices at the regional level.	Dr. Romney		Mar-07 & Ongoing	Dr. Romney and J. Curtin sit on the Regional Infection Control Committee. Dr. Romney presents PHC data to the Regional Infection Control Committee.
4.3.4 Promote current and accepted language and policies recognized by national and international IC/public health agencies.	Dr. Romney		Complete & Ongoing	IPAC team reviews national and international journals on a weekly basis, for changes in best practice. Policy changes based on these reviews then go to the Infection Control Standards Committee.
Objective 4.4:				
Play a leadership role in the design and implementation of a provincial IC strategy.	IPAC Team		Complete & Ongoing	IPAC team continues to collaborate with: <ul style="list-style-type: none"> • PICNet BC • BCCDC • CHICA B.C. Chapter Drs. Romney sits on the PICNet advisory committee. IPAC is represented on the local chapter of CHICA.
Objective 4.5:				
Play a leadership role in the design and implementation of a national IC strategy.	Dr. Romney, M. McNaughton		Complete & Ongoing	Dr. Romney provides feedback and advice to: <ul style="list-style-type: none"> • Canadian Patient Safety Institute • Public Health Agency of Canada • US CDC M. McNaughton is a past president of CHICA Canada.
Objective 4.6:				

Actions	Lead Members	Start Date	Completion Date	Status
Participate in regional/provincial/national IC initiatives.	IPAC Team		Complete & Ongoing	Examples of IPAC participation with: <ul style="list-style-type: none"> • PICNet for CDAD and ARO initiatives • VCH RICC for the sharing of ideas and materials • VCH by sharing of IPAC web based manual • VCH, FHA, BCCA, BCCH by sharing the PHC Hand Hygiene e-learning education module • J. Curtin President, B.C. Chapter, CHICA • FHA, PHC, VCH lower mainland collaborative • PHC and BCCDC collaborative lab services • Dr. Champagne, President of B.C. Association of Medical Microbiologists • PHC has provided a physician based e-learning module to BCCA, BCCH. This educational tool will be adopted by VCH and FHA in 2009/10.
Goal 5: Resource Management & Quantity of appropriate service.				
Measure:				
Achieve recognized Health Canada standards for Infection Control staffing.	H. Green		Jan09 complete	Quebec staffing level standards for ICP ratio per inpatient bed have been used to fairly allocate ICP labour hours to each nursing unit. Consistently assigned ICPs with dedicated nursing units will be able to understand IPAC needs of the area, and fulfill those needs. Backup ICPs have also been identified for each nursing unit.
Objective 5.1:				
Ensure IC Team has a resource plan to support the implementation of appropriate IC standards at PHC.				
5.1.1 Start IPAC Annual Strategic	Dr. Romney	Apr-05	Mar-05	IPAC strategic plan is reviewed annually.

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Planning process				
5.1.2 Ensure appropriate regional resources are allocated to PHC to accomplish the Strategic Plan.	Dr. Mithani, Dr. Sherlock, Dr. Romney	May-05	Mar-07	IPAC now has a dedicated cost centre.
5.1.5 Promote IC involvement in optimizing the physical design of patient care areas to enable compliance with IC standards.	Dr. Romney	Ongoing	Complete & Ongoing	ICPs on construction and renovation planning committees to ensure that IPAC standards are followed.
Objective 5.2:				
Collaborate with Programs to improve the movement of isolation patients to enable more efficient patient flow.				
5.2.1 Provide IC expertise to the programs for the efficient transfer of patients within the organization, while maintaining appropriate IC precautions.	M. McNaughton	Jun-05	Mar-08	IPAC was consulted during the development of the Overcapacity Protocol to efficiently decant the ED.
5.2.2 Work with Emergency Preparedness to address community to hospital spread of relevant infectious agents; ensure a rapid response to emerging pathogens with an Emergency Department focus.	Dr. Romney, Dr. Sherlock		Complete & Ongoing	Have worked with EP to use the Hospital Emergency Incident Command System (HEICS) Structure in large scale outbreaks and working with EP in the development of a PHC pandemic influenza plan.
5.2.3 Explore methods for identifying and controlling infections as they present to the Emergency Department.	Dr. Romney		Ongoing	07/08 worked with the ER department and CI by way of a recommendation form the ICCs to develop screening of ER patients for AROs where the patient is to be admitted to and IPU. 06/07/08 worked with Planning and the ER teams in the multi phase ER renovation project. IPAC pocket cards developed for transmission based precautions. IPAC and the ER collaborate to improve HH compliance and implement flow charts (e.g. ILI flowchart for triage, precautions, and patient management).

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5.2.4 Assign IC Practitioners to specific projects.	IC Team		Mar-07 and ongoing	IPAC weekly team meetings are an excellent venue for project management.
Objective 5.3:				
Ensure staff have space and equipment available to do the work.			Mar-07	In 2006/07 IPAC moved to new offices at Hornby site.
5.3.1 Perform an inventory of office space and computer hard/software.	J. Curtin		Mar-06	
5.3.2 Obtain convenient and appropriate meeting space.	IPAC Clerk		Complete	Since 2006/7 IPAC meeting space has been available for weekly meetings. Bookings for project team meetings are readily available.

Actions	Lead Members	Start Date	Completion Date	Status
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GLOSSARY:				
CI				PHC Change Initiatives
CRBSI				Catheter-related Bloodstream Infection
IPAC				Infection Prevention and Control
ICC				Infection Control Champion (local Infection Control expert)
ICEPT				Infection Control Emergency Preparedness Team
ICP				Infection Control Practitioner (usually a RN)
MRSA				Methicillin Resistant <i>Staphylococcus aureus</i>
OMT				Outbreak Management Team
PHC				Providence Health Care
SLT				Senior Leadership Team
SSI				Surgical Site Infection (formerly Surgical Wound Infection)
TB				Tuberculosis
VAP				Ventilator Assisted Pneumonia
VRE				Vancomycin-Resistant Enterococci
Additions June 08				
ARO				Antibiotic Resistant Organism
AC				Acute Care
RC				Residential Care
HC				Health Canada
CDC				Centers for Disease Control and Prevention
BC				British Columbia
PICNet				Provincial Infection Control Network BC
VCH				Vancouver Coastal Health
OCP				Over Capacity Protocol

Goal Area	Project/Objective	Lead Members	Evidence of Completion (metric)	Due Date	Start Date	Complete Date
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Infection Prevention and Control (IPAC) STRATEGIC PLAN for Apr-09 to Mar-11

* draft 30Jun09 - pending lower mainland collaborative decisions *

Consistent with, and in the context of, the Values and Mission of Providence Health Care.

The *Vision* of the Infection Control Team is to create and sustain a culture in which infection control is integrated into all aspects of care. The

The Mission of the Infection Control Team is to be dedicated to the prevention and control of health care acquired infections in a supportive working environment. The practices of the Infection Control Team will be based on sound scientific principles. Infection control services will be provided to Providence Health Care with structure and authority in collaboration with local, regional and provincial partners.

PAC Team Members:

Name	Title
Marc Romney MD, FRCPC, DTM&H	Director, IPAC & Microbiology
Howard Green B.Sc. M.B.A.	Team Leader, IPAC
Mark Hull MD, FRCPC	Physician, Acute Care, IPAC
Debbie Jacobson MD, CCFP	Physician, Residential, IPAC
Jayne Bradbury B.Sc. M.P.A.	Epidemiologist
Jim Curtin RN, BSN, CIC	ICP
Mary McNaughton RN, BSN, MSA,	ICP
Craig Pienkowski RN, BN, BSc	ICP
Stuart Gray RN, MSc, DLSHTM	ICP
Wayne Gilbert RN, BSc (Hons)	ICP
Azra Sharma RT B.Sc. M.Sc.	ICP
Christopher Sherlock MD, FRCPC	Medical Microbiologist
Sylvie Champagne MD, FRCPC	Medical Microbiologist
Luz Vierneza	Clerk

Goal Area	Project/Objective	Lead Members	Evidence of Completion (metric)	Due Date	Start Date	Complete Date
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1.0 Leadership						
	1.1 Request a 7th ICP to bring IPAC closer to national and provincial standards. Example areas which are under-serviced now include outpatient areas, community dialysis, and new facilities (e.g. Honoria Conway).	H. Green	Meet Quebec standard for ICP/acute bed ratio and ICP/resident bed ratio.	Apr-10		
	1.2 Continue the Infection Control Champion project on an ongoing basis by implementing a PHC-wide IPAC Link Nurse program.	H. Green J. Curtin W. Gilbert		Sep-09		
	1.3 Revise and update terms of reference for IPAC Standards Committee	H. Green M. Romney		Sep-09		
	1.4 Develop new contracts for sessional physicians	H. Green R. Romney	Signed contracts to Medical Affairs.	Jul-09		Jul-09
	1.5 Collaborate with FHA and VCH as a future cost avoidance strategy.	J. Etherington H. Green M. Romney	<ul style="list-style-type: none"> ❑ number of standardized IPAC processes ❑ number of standardized report indicators ❑ cost avoidance savings ❑ existence of a regional plan 	Dec-09 for plan		
	1.6 Apply for awards to recognize contributions made by IPAC staff	W. Gilbert	PHC received the Oxoid Infection Control Special Judges Award for Excellence in infection prevention and control. The Oxoid Judges felt that the submission, "Crisis in Vancouver" was highly commendable and	Apr-09		Jun-09

Goal Area	Project/Objective	Lead Members	Evidence of Completion (metric)	Due Date	Start Date	Complete Date
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			<p>deserved to be recognized. "The Oxoid Infection Control Team of the Year Awards are open to infection prevention and control teams worldwide" says Fiona Macrae, awards manager. "We are delighted to make a Judges Special Award to the infection control team at Providence Health Care for the work that they have undertaken, not only reducing levels of nosocomial infections, including VRE, which does not commonly feature in Awards entries, but also reducing infections in intravenous drug users and homeless persons in the local community."</p>			
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	<p>1.7 Clarify roles and responsibilities for IPAC Team</p>	<p>H. Green</p>	<p>Fully implemented system:</p> <ul style="list-style-type: none"> ❑ Dedicated ICPs assigned to nursing units and outpatient areas ❑ Each team member assigned projects as per strategic plan ❑ Projects managed via electronic collaborative work spaces 	<p>Sep-09</p>		
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Goal Area	Project/Objective	Lead Members	Evidence of Completion (metric)	Due Date	Start Date	Complete Date
	1.8 Survey key IPAC customers for satisfaction levels	H. Green, J. Bradbury, E. Lloyd-Smith	Satisfaction surveys completed by key IPAC customers	Apr-10		
	1.9 Implement improved scheduling hours for staff	H. Green	Staff and management satisfaction with scheduling	Sep-09		
2.0 Surveillance						
	2.1 Improve existing surveillance systems – obtain feedback from users		User satisfaction with surveillance reports	Dec-10		
	2.3 Evaluate Critical Care Database as a potential tool for VAP Surveillance.	J. Bradbury, E. Lloyd-Smith	Evaluation Report with recommendations.	Aug-10		
	2.2 Develop a VAP surveillance system	J. Bradbury, E. Lloyd-Smith, J. Curtin		Mar-10		
	2.3 Develop a CLI surveillance system	J. Bradbury, E. Lloyd-Smith, J. Curtin	Quarterly published HAI rates for CLI. <i>Automated, lab-based CLI surveillance is currently being piloted. Introduction of central line insertion form may also be incorporated in to the surveillance system. Early fiscal 2009-2010 – anticipated introduction of central line insertion form by Critical Care group. This form will provide additional data about central line days and patients with lines.</i>	Dec-10		
	2.4 Expand SSI surveillance system and published reports.	J. Bradbury, E. Lloyd-Smith	Quarterly published HAI rates for SSI <input type="checkbox"/> Orthopedics <input type="checkbox"/> C-section in hospital	Dec-09 Sep-09 Mar-10		

Goal Area	Project/Objective	Lead Members	Evidence of Completion (metric)	Due Date	Start Date	Complete Date
			<input type="checkbox"/> C-section post discharge <input type="checkbox"/> Cardiac surgery sternal wound infection rates	Mar-10		
	2.4 Expand C-section surveillance system to include post-discharge	J. Bradbury, E. Lloyd-Smith	Post discharge C-section SSI rates	Apr-10		
	2.5 Develop a surveillance system for antimicrobial use and resistance	M. Romney J. Bradbury, E. Lloyd-Smith	Phase 1 – Literature reviews	Dec-10		
	2.6 For Hemodialysis: <input type="checkbox"/> Enhance routine screening for HBV and HCV screening at PHC <input type="checkbox"/> Develop surveillance system for HBV and HCV.	J. Bradbury, E. Lloyd-Smith J. Curtin	Compliance with screening orders. Quarterly prevalence rate reports.	Oct-09		
	2.7 Evaluate compliance with ARO screening compliance	J. Bradbury, E. Lloyd-Smith				
3.0 Policy & Procedures						
	3.1 Develop and implement a new corporate policy for hand hygiene (to be aligned with standard precautions)	A. Sharma, M. McNaughton		Aug-09		
	3.2 Revise pet policies for acute and residential care.	A. Sharma		Sep-09		
	3.3 Develop an residential care policy for pneumococcal vaccine	D. Jacobson H. Green		Sep-09		
4.0 Outbreak Management						
	4.1 Prospective review of al 2008/09	D. Jacobson	Report with	Sep-09		

Goal Area	Project/Objective	Lead Members	Evidence of Completion (metric)	Due Date	Start Date	Complete Date
	outbreaks to determine "lessons learned"		recommendations.			
	4.2 Develop improved outbreak checklists for: <ul style="list-style-type: none"> ❑ CDAD ❑ Norovirus 	D. Jacobson		Sep-09		
	4.3 Update the IPAC sections of the PHC Pandemic Plan.	J. Curtin, M. McNaughton in consultation with Emergency Preparedness		Oct-09		
5.0 Education						
	5.1 Develop plan and support for CIC certification for ICPs not yet certified	H. Green	% of ICPs preparing for exam % of ICPs with CIC	Mar-10		
	5.2 Determine the level of infection control knowledge using a random survey tool The previous tool tested was not challenging enough for staff. All scores were exceedingly high (> 95%), demonstrating that the survey tool is unable to identify knowledge gaps amongst staff.	J. Bradbury, E. Lloyd-Smith	Survey results	Oct-09		
	5.3 Implement a fair and equitable system to share education dollars.	H. Green				
	5.4 Develop and implement an education plan for PHC staff.	A. Sharma, W. Gilbert	Education plan available on the intranet with ability for staff to sign up for courses. Staff knowledge survey	Dec-09		
	5.5 Develop and implement an education plan for PHC patients and visitors.	M. McNaughton, H. Green	Plan with metrics, e.g.: Patient knowledge survey Visitor knowledge survey	Mar-10		

Goal Area	Project/Objective	Lead Members	Evidence of Completion (metric)	Due Date	Start Date	Complete Date
	5.6 Develop and implement an education plan for PHC physicians.	D. Jacobson	Plan with metrics, e.g. Physician knowledge survey			
	5.7 Improve e-learning module and tracking system for physicians and distribute this module to VCH and FHA.	D. Jacobson, H. Green	Revised module published. User satisfaction survey.	Aug-09		
	5.8 Develop an e-learning hand hygiene module for nurses and allied staff.	D. Jacobson W. Gilbert	Module with quiz evaluation on the intranet	Oct-09		
	5.9 Develop a e-learning hand hygiene module for transmission-based precautions	D. Jacobson	Module with quiz evaluation on the intranet	Jan-10		
	5.10 Complete an educational need surveys & analysis for key audiences	J. Bradbury, H. Green		Nov-10		
	5.11 Mentor one ICP every two years	J. Curtin, M. McNaughton	Student evaluation completed (e.g. UBC Path 451)	Sep-09		
6.0 Communication, Reporting, Marketing						
	6.1 Develop a reporting system for front line staff. That is, provide feedback for their improvement efforts.	J. Bradbury, C. Pienkowski, E. Lloyd-Smith	Weekly, Period, or Quarterly results of IPAC indicators to be posted in each nursing report room.	Sep-10		
	6.2 Change PHC-wide IPAC screen savers to WHO 5 moments screen saver	H. Green	Screen saver changed.	Apr-09		
	6.3 Participate in annual World Hand hygiene day	IPAC Team	Participation noted on the WHO website	May-09		May-09
	6.3 Publish quarterly and annual reports based on user needs	J. Bradbury, E. Lloyd-Smith	Scheduled and implemented report release dates.	Sep-09		
	6.4 Develop a score card of IPAC indicators.	J. Bradbury, E. Lloyd-Smith	Published score card.	Apr-10		
	6.5 Continue with the expansion of the talking walls/reminder system program.	J. Curtin, W. Gilbert	Staff survey results for each type of reminder.	Mar-10		

Goal Area	Project/Objective	Lead Members	Evidence of Completion (metric)	Due Date	Start Date	Complete Date
7.0 QI & Root Cause Analysis (RCA)						
	7.1 Reduce VRE Blood Stream Infections	J. Curtin	Complete RCA report with recommendations	Jul-09	Jun-09	
	7.2 Review all readmissions within 30 days for SPH HAI cases.	D. Jacobson	Complete RCA report with recommendations	Mar-10		
	7.3 Complete analysis of Infection Control Champions (ICC) project ICC and meet all conditions of the CIHR grant,	J. Bradbury, E. Lloyd-Smith		Oct-09		
	7.4 Write final report for IC project.	J. Curtin, W. Gilbert	Complete, final ICC report containing all elements of a published scientific paper.			
	7.5 Review all PHC mortality cases with a PHC HAI	D. Jacobson	Complete M&M report with recommendations	Mar-10		
	7.5 Complete an external review of the OR in terms of IPAC best practices	H. Green, M. McNaughton	Completed 3M report with recommendations	Jul-09		Jul-09
8.0 Hand Hygiene						
	8.1 Implement a PHC interdisciplinary hand hygiene committee – leadership to be provided by IPAC Team	H. Green	Committee in place.	Sep-09		
	8.2 Develop a “marketing/advertising” plan to improve staff compliance rates.	H. Green	Plan with actions	Oct-09		
	8.3 Implement system to measure hand hygiene compliance	J. Bradbury, E. Lloyd-Smith	Quarterly hand hygiene compliance reports	Jun-09		
	8.4 Evaluate availability of hand hygiene equipment and supplies	H. Green	% of dispensers empty or broken	Sep-09		
	8.5 Evaluate availability of point of care (at bedside) Microsan in two trial areas: ICU and 9c/d	H. Green, W. Gilbert, J. Curtin		Sep-10		
9.0 Precautions						

Goal Area	Project/Objective	Lead Members	Evidence of Completion (metric)	Due Date	Start Date	Complete Date
	9.1 Work collaboratively with FHA, VCH and PHSA to standardize all levels of precaution based standards, signage, fact sheets, education modules, and communiqués.	H. Green	% of lower mainland standardization for IPAC Precautions.			
10.0 ICP Training & CIC Certification						
	10.1 Implement an annual performance review system.	H. Green	ICPs performance review completed	Sep-09		
	10.2 Complete inventory of educational resource materials (e.g. books, journals, software)	Luz, M. McNaughton	Inventory posted on the shared file system.	Sep-09		
11. Accreditation						
	11.1 Ensures with PHC complies with Accreditation Canada Service room recommendations.	H. Green, Camille	Service room audits completed quarterly. Interim reports to Accreditation Canada have been completed.	Jan-10		
	11. 1 Obtain zero recommendations related to IPAC in the 2010 survey. Comply with all Accreditation Canada IPAC standards.	H. Green, A. Sharma, M. McNaughton	Number of survey recommendations. Internal evaluation of compliance with accreditation standards.	Nov-10		
12. Construction						
	12.1 Collaborate with PHC Planning and Development in design phase for future construction - to ensure it meets AIA and CSA standards. Collaborate with PHC Planning and Development as well as Workplace	M. McNaughton J. Curtin C. Pienkowski	IPAC works with Planning and Development during key planning stages. SPH Emergency	Nov-10 June		

Goal Area	Project/Objective	Lead Members	Evidence of Completion (metric)	Due Date	Start Date	Complete Date
	Wellness and Safety to ensure renovations meet CSA standards for Infection control during construction and renovation, including dust control.		Renovation project is due for completion in 2010.	2010		
13. Product Review						
	13.1 Review of IPAC and epidemiological software that is currently available in the marketplace.	J. Bradbury, E. Lloyd-Smith	Completion of literature review.	Mar-10		
14. Reprocessing						
	14.1 Work collaboratively with FHA, VCH and PHSA to standardize reprocessing standards, signage, fact sheets, educational modules, and communiqués.	H. Green	% of lower mainland standardization for reprocessing.			
15. Environmental Cleaning						
	15.1 Participate in Lower Mainland committees and standardize approach to environmental cleaning.	M. Romney J. Curtin	Costs avoided measured on a quarterly basis.	Apr-10		

ICP Responsibilities by Area			Appendix C	
	22/7/2009			
PHC Site	Operations Leader	Clinical Area	ICP Responsibility	ICP Back-up
SPH	Bazley, Sandra (68619)	7A	Wayne (69373)	Mary (68187)
SPH	Bazley, Sandra (68619)	7B	Wayne (69373)	Mary (68187)
SPH	Bedell, Barb (68445)	10A/B	Craig (69412)	Stuart (66091)
SPH	Bedell, Barb (68445)	8C	Mary (68187)	Craig (69412)
SPH	Bray, Blaine (69848)	2E	Mary (68187)	Wayne (69373)
SPH	Bray, Blaine (69848)	2N	Mary (68187)	Wayne (69373)
SPH	Bray, Blaine (69848)	9A	Wayne (69373)	Azra (63223)
BF	Briggs, Marion (69705)	BF3	Wayne (69373)	Azra (63223)
BF	Briggs, Marion (69705)	BF4	Wayne (69373)	Azra (63223)
SPH	Brown, David	General Emergency	Craig (69412)	Azra (63223)
SPH	Carleton, Julie (68995)	5C	Stuart (66091)	Craig (69412)
SPH	Carleton, Julie (68995)	5D	Stuart (66091)	Craig (69412)
SPH	Carleton, Julie (68995)	CSSU, Cath Labs, Cardiac Procedure Room, EP Lab	Stuart (66091)	Craig (69412)
SPH	Carne, Jean (68600)	5A	Stuart (66091)	Craig (69412)
SPH	Carne, Jean (68600)	CCU	Jim (68052)	Wayne (69373)
SPH	Chow, Cecilia	CDU - Sechelt	Jim (68052)	Wayne (69373)
SPH	Chow, Cecilia	CDU - Vancouver	Jim (68052)	Wayne (69373)
SPH	Chow, Cecilia	CDU - Richmond	Jim (68052)	Wayne (69373)
SPH	Chow, Cecilia	CDU - Squamish	Jim (68052)	Wayne (69373)
SPH	Chow, Cecilia	CDU - Powell River	Jim (68052)	Wayne (69373)
SPH	Chow, Cecilia	CDU - North Shore	Jim (68052)	Wayne (69373)
SPH	Chow, Cecilia	Home Hemodialysis	Jim (68052)	Wayne (69373)
MSJ	Clark, Liz (78542)	MICU	Azra (63223)	Stuart (66091)

ICP Responsibilities by Area			Appendix C	
	22/7/2009			
PHC	Operations	Clinical	ICP	ICP
Site	Leader	Area	Responsibility	Back-up
MSJ	Clark, Liz (78542)	General Emergency	Azra (63223)	Stuart (66091)
SPH	Duff, Jennifer (69255)	MHC	Mary (68187)	Craig (69412)
SPH	Duff, Jennifer (69255)	SCN	Mary (68187)	Craig (69412)
SPH	Duff, Jennifer (69255)	3MC	Mary (68187)	Stuart (66091)
MSJ	Elliott, Cindy (78131)	M3E	Stuart (66091)	Mary (68187)
MSJ	Elliott, Cindy (78131)	M3W	Stuart (66091)	Mary (68187)
SPH	Elworthy, Anastasia (69294)	GI Clinic - St Paul's	Wayne (69373)	Mary (68187)
SPH	Elworthy, Anastasia	Ophthalmology Clinic	Wayne (69373)	Mary (68187)
SPH	Elworthy, Anastasia	Foot and Ankle Clinic	Wayne (69373)	Stuart (66091)
SPH	Elworthy, Anastasia	Ear Nose and Throat	Wayne (69373)	Stuart (66091)
SPH	Elworthy, Anastasia	Ambulatory Care	Wayne (69373)	Stuart (66091)
SPH	Elworthy, Anastasia	8D	Mary (68187)	Craig (69412)
SPH	Foran, Jeannie (internal)//Grimwood, Sandra (external)	Operating Room	Mary (68187)	Jim (68052)
SPH	Grimwood, Sandra (69948)	Pre-Admission Clinic	Wayne (69373)	Stuart (66091)
SPH	Grimwood, Sandra (69948)	PAR	Mary (68187)	Craig (69412)
SPH	Grimwood, Sandra (69948)	SDC	Mary (68187)	Craig (69412)
SPH	Harrison, Scott (63312)	Infectious Diseases Clinic	Azra (63223)	Stuart
SPH	Harrison, Scott (63312)	10C	Azra (63223)	Wayne (69373)
Langara	Johnson, Rae (69755)	Aspen	Craig (69412)	Jim (68052)
Langara	Johnson, Rae (69755)	Birch	Craig (69412)	Jim (68052)
Langara	Johnson, Rae (69755)	Cedar	Craig (69412)	Jim (68052)
SPH	Jones, Lynn (66362)	Eating Disorders Clinic	Azra (63223)	Stuart (66091)
SPH	Jones, Lynn (66362)	4NW	Mary (68187)	Stuart (66091)
SPH	Kille, Julie (A)	Chronic Pain Program	Azra (63223)	Stuart (66091)
SPH	Kille, Julie (A)	Mental Hlth Outpatient Clinic	Azra (63223)	Stuart (66091)
SPH	Kille, Julie (A)	APCA	Azra (63223)	Stuart (66091)

ICP Responsibilities by Area			Appendix C	
	22/7/2009			
PHC Site	Operations Leader	Clinical Area	ICP Responsibility	ICP Back-up
SPH	Lawlor, Cindy (69649)	CSICU	Jim (68052)	Wayne (69373)
SPH	Lawlor, Cindy (69649)	5B	Stuart (66091)	Craig (69412)
SPH	Lawlor, Cindy (69649)	Perfusion, Cardiac Echo	Stuart (66091)	Craig (69412)
SPH	Maudee, Amber (68629)	ICU	Jim (68052)	Wayne (69373)
SPH	McCullough, Grant (69659)	Cystic Fibrosis Specialty Clinic	Wayne (69373)	Mary (68187)
SPH	McCullough, Grant (69659)	7C	Craig (69412)	Wayne (69373)
SPH	McCullough, Grant (69659)	7D	Craig (69412)	Wayne (69373)
SPH	McCullough, Grant (69659)	8A	Mary (68187)	Craig (69412)
HFH	Mooney, Blake (22650)	HEC1	Azra (63223)	Jim (68052)
HFH	Mooney, Blake (22650)	HEC2	Azra (63223)	Jim (68052)
MSJ	Selman, Jen (22611)	Geri-Day Hospital	Azra (63223)	Stuart (66091)
MSJ	Selman, Jen (22611)	M4E	Azra (63223)	Stuart (66091)
HFH	Selman, Jen (22611)	HRB1	Jim (68052)	Mary (68187)
HFH	Selman, Jen (22611)	HRB2	Jim (68052)	Mary (68187)
MSJ	Shewella, Sharon (78373)	Operating Room	Mary (68187)	Craig (69412)
MSJ	Shewella, Sharon (78373)	DT Procedure Rooms	Mary (68187)	Craig (69412)
MSJ	Shewella, Sharon (78373)	Post Anaesthesia Recovery	Mary (68187)	Craig (69412)
MSJ	Shewella, Sharon (78373)	M4W	Azra (63223)	Stuart (66091)
MSJ	Shewella, Sharon (78373)	SDC	Azra (63223)	Stuart (66091)
MSJ	Shewella, Sharon (78373)	Endoscopy	Azra (63223)	Stuart (66091)
SPH	Skihar, Anita	Diabetes Clinic	Wayne (69373)	Mary (68187)
SPH	Skihar, Anita	Diabetic Weekend Clinic	Wayne (69373)	Mary (68187)
SPH	Skihar, Anita	Hemoglobinopathy Clinic	Wayne (69373)	Mary (68187)
SPH	Skihar, Anita	Thyroid-Endocrinology Clinic	Wayne (69373)	Mary (68187)

ICP Responsibilities by Area			Appendix C	
	22/7/2009			
PHC Site	Operations Leader	Clinical Area	ICP Responsibility	ICP Back-up
SPH	Skihar, Anita	Respiratory Specialist Clinic	Wayne (69373)	Mary (68187)
SPH	Skihar, Anita	Medical Short Stay Unit	Wayne (69373)	Mary (68187)
SPH	Skihar, Anita	Rapid Access Clinic	Wayne (69373)	Mary (68187)
SPH	Skihar, Anita	EEG/EMG/EP, Home Enteral Nutrition/Hemosiderosis, Home IV	Wayne (69373)	Mary (68187)
SPH	Sullivan, Catherine (69035)	Renal Vascular Access	Jim (68052)	Wayne (69373)
SPH	Sullivan, Catherine (69035)	6D	Jim (68052)	Azra (63223)
SPH	Tabrizi, Simin (69154)	10D	Azra (63223)	Wayne (69373)
SPH	Tabrizi, Simin (69154)	9C/D	Wayne (69373)	Azra (63223)
SPH	Tabrizi, Simin (69154)	Marion Hospice	Mary (68187)	Azra (63223)
SPH	Trask, Michele (69337)	Peritoneal Dialysis Unit	Jim (68052)	Wayne (69373)
SPH	Trask, Michele (69337)	Kidney Function Centre	Jim (68052)	Wayne (69373)
SPH	Trask, Michele (69337)	Integrated Care Clinic	Jim (68052)	Wayne (69373)
SPH	Trask, Michele (69337)	Renal Transplant Clinic	Jim (68052)	Wayne (69373)
SPH	Trask, Michele (69337)	6B	Jim (68052)	Azra (63223)
MSJ	Wong, Jocelyne (78542)	M1S	Stuart (66091)	Mary (68187)
MSJ	Wong, Jocelyne (78542)	MEC2	Azra (63223)	Stuart (66091)
MSJ	Wong, Jocelyne (78542)	M2W	Stuart (66091)	Mary (68187)
Youville	Wong, Rebecca (68539)	YOU2	Stuart (66091)	Jim (68052)
Youville	Wong, Rebecca (68539)	YOU3	Stuart (66091)	Jim (68052)
Youville	Wong, Rebecca (68539)	YOU4	Stuart (66091)	Jim (68052)
Youville	Wong, Rebecca (68539)	YOU5	Stuart (66091)	Jim (68052)
SPH	Yong, Melodie (66243)	Tansplant Clinic	Stuart (66091)	Craig (69412)
SPH	Yong, Melodie (66243)	Heart Function Clinic	Stuart (66091)	Craig (69412)
SPH	Yong, Melodie (66243)	Pacific Adlt Congenitl Hrt Clin	Stuart (66091)	Craig (69412)
SPH	Yong, Melodie (66243)	Pacemaker Clinic	Stuart (66091)	Craig (69412)

ICP Responsibilities by Area			<i>Appendix C</i>	
	22/7/2009			
PHC	Operations	Clinical	ICP	ICP
Site	Leader	Area	Responsibility	Back-up
SPH	Yong, Melodie (66243)	Healthy Heart Program	Stuart (66091)	Craig (69412)
		Radiology	Mary (68187)	Wayne (69373)
		Laboratory	Azra (63223)	Craig (69412)
		Physiotherapy	Jim (68052)	Wayne (69373)
		EEG/Cardio/ECG	Stuart (66091)	Mary (68187)
		nuc med/ultrasound	Wayne (69373)	Jim (68052)
		Pharmacy	Stuart (66091)	Jim (68052)

IPAC - Lower Mainland Collaborative Work Plan		draft 15May09 # = priority <i>Appendix D</i>					
	IPAC Program Responsibilities *	Work Group	Objective(s)	#	Leader	Evidence of Completion	Dates: Due Start Complete
1.0	Key Mandate/Goals of the IPAC Program						
	<i>Two key goals of an infection prevention and control program are:</i>						
1.1	to protect clients/patients/residents from health care-associated infections, resulting in improved survival rates, reduced morbidity associated with infections, shorter length of hospital stay and a quicker return to good health.						
1.2	to prevent the spread of infections from patient-to-patient, from patients to health care providers, from health care providers to patients, from health care providers to health care providers and to visitors and others in the health care environment.						
	These goals are relevant to care activities across the spectrum of health care settings including acute care, complex continuing care, rehabilitation hospitals, long-term care homes, ambulatory settings, outpatient surgery facilities and home health care programs.						
1.3	In order to achieve these goals in a cost-effective manner, an active, effective, organization-wide infection prevention and control program must be developed and continuously supported by senior administration.						
2.0	Core IPAC Functions						
	<i>The core functions of infection prevention and control in both hospital and non-hospital settings focus on strategies to protect clients/patients/residents, staff and others from exposures to infections. These include:</i>						
2.1	management of critical data and information, including surveillance for nosocomial and other infections.						
2.2	implementation of evidence-based practice, standards and guidelines through setting-specific policy and procedure.	Policy & Procedure					D _____ S _____ C _____

	IPAC Program Responsibilities *	Work Group	Objective(s)	#	Leader	Evidence of Completion	Dates: Due Start Complete
2.3	direct interventions to prevent the transmission of infection, including outbreak prevention and control.						
2.4	effective occupational health programs (including healthy workplace policies and immunization services).						
2.5	education and training of health care providers, clients/patients/residents and their families.**	Education					D _____ S _____ C _____
2.6	communication of infection-related issues and relevant practices to leaders and staff to facilitate improvement.	Communication, Reporting, Marketing, Advertising, Behavioural Change					D _____ S _____ C _____
2.7	ongoing evaluation and continuous improvement of the IPAC program.						
2.8	adequate medical coverage	Medical Coverage					D _____ S _____ C _____
2.9	The success of the IPAC program is defined by the organization's effectiveness in preventing the occurrence, or limiting the spread, of health care-associated infections. The <u>selection of appropriate process and outcome surveillance indicators</u> will reflect the specific goals of the organization. In particular, outcome indicators should reflect the efficacy of the organization in protecting clients/patients/residents, health care providers, visitors and others from HAIs as well as determine the cost-effectiveness of the program activities.						
3.0	Best Practice to support Goals & Function						
3.1	All PHC health care settings must assess needs for, develop, provide and evaluate an active, effective infection prevention and control program that meets the mandate and goal to decrease the risk of health care-associated infections and improve health care safety.						

	IPAC Program Responsibilities *	Work Group	Objective(s)	#	Leader	Evidence of Completion	Dates: Due Start Complete
3.2	Continuing support for the infection prevention and control program must be an organizational priority.						
3.3	Infection prevention and control activities should be based on a <u>continuous quality improvement approach where the processes and outcomes are continuously reviewed and improved</u> . Prior to implementing an IPAC program, and periodically thereafter, there should be an initial review of the entire facility or organization for the strengths, weaknesses, opportunities and threats related to infection prevention and control practices (i.e. <u>SWOT analysis</u>). The results from this analysis may be used to assist in prioritizing the needs of the program.	Surveillance (MRSA, VRE, CDAD)					D _____ S _____ C _____
4.0	Structure of the IPAC Program						
4.1	Individuals with appropriate academic and practice credentials, training and experience related to health care infection prevention and control programs are responsible for directing infection prevention and control activities including implementing, monitoring and evaluating the IPAC program with the support of senior administration and the infection prevention and control committee. The ICP(s) should have direct access to the Senior Management individual who is accountable for the organization's program and who can facilitate the actions that are required.	Steering & Planning Committee					D _____ S _____ C _____
5.0	Elements of the IPAC Program						
	The elements of the infection prevention and control program must be based on the type of health care setting. <u>Elements of this program will have resource implications</u> for other areas and departments of the facility as well as Infection Prevention and Control (e.g. Occupational Health and Safety, Laboratory Services, Environmental Services).						
	Infection prevention and control programs should include the following:						

	IPAC Program Responsibilities *	Work Group	Objective(s)	#	Leader	Evidence of Completion	Dates: Due Start Complete
5.1	a hand hygiene program.	Hand Hygiene					D _____ S _____ C _____
5.2	surveillance based on systematic data collection to identify infections, subsequent analysis of data and timely dissemination of results.	see 3.3					
5.3	a system of precautions to reduce the risk of transmission of infectious agents (i.e. Routine Practices, Additional Precautions).	Precautions					D _____ S _____ C _____
5.4	continuing education for health care providers in infection prevention and control.	see 2.5					
5.6	a system for detection, investigation and control of health care-associated outbreaks.	Outbreak Management					D _____ S _____ C _____
5.7	infection prevention and control policies and procedures.	see 2.2					
5.8	process audits.	QI					D _____ S _____ C _____
5.9	a resident health program that addresses the prevention and control of infectious disease (e.g. long-term care homes).						
5.10	elements of an occupational health program for health care providers related to transmission of microorganisms.						
5.11	a system for antibiotic review and control.	Antibiotic Review					D _____ S _____ C _____
5.12	reportable disease reporting to public health authorities.						
5.13	timely access to microbiology laboratory reports and expertise.						
5.14	active participation in all phases of facility design and construction/renovation.	Construction					D _____ S _____ C _____
5.15	product review and evaluation.	Product Review					D _____ S _____ C _____

	IPAC Program Responsibilities *	Work Group	Objective(s)	#	Leader	Evidence of Completion	Dates: Due Start Complete
5.16	review of care policies and procedures for practices impacting on infection prevention and control.						
5.17	continuous quality improvement activities.						
5.18	review of practices for reprocessing of equipment	Reprocessing					D _____ S _____ C _____
5.19	review of practices for environmental cleaning	Environmental					D _____ S _____ C _____
5.20	participation in research activities for programs affiliated with academic health science centres, teaching hospitals and other settings that have the capability of doing these activities.						
6.0	Best Practice to support Structure & Elements						
6.1	PHC settings must evaluate their infection prevention and control needs and then implement an infection prevention and control program suited to those needs.						
6.2	Periodic review of the infection prevention and control program must be carried out to reassess the organization's needs and to determine which elements are required to continue to meet the goals of the program for that health care setting.	Accreditation					D _____ S _____ C _____
6.3	Senior administration and the Infection Prevention & Control Committee must support the implementation and execution of the infection prevention and control program by the infection prevention and control staff.						
*	http://www.health.gov.on.ca/english/providers/program/infectious/diseases/best_prac/bp_ipcp_20080905.pdf						
	©Ontario Ministry of Health and Long-Term Care/Public Health Division/Provincial Infectious Diseases Advisory Committee						
	SBN # 978-1-4249-4832-1 [English version]	Sep-08					

**	Effective infection prevention and control education programs should emphasize:						
	Disease transmission, the risks associated with infectious diseases and basic epidemiology of health care-associated infections specific to the setting;						
	The benefits of case finding/surveillance and the extent and nature of existing and potential problems related to infection in the organization (e.g. MRSA, VRE);						
	Hand hygiene and basic personal hygiene, including the use of alcohol-based hand rubs and hand washing;						
	Principles and components of Routine Practices as well as additional transmission-based precautions;						
	Assessment of the risk of infection transmission and the appropriate use of personal protective equipment (PPE), including safe application, removal and disposal;						
	Appropriate cleaning and/or disinfection of health care equipment, supplies and surfaces or items in the health care environment (e.g. beds, bed tables, call bells, toilets, privacy curtains);						
	Aseptic practices;						
	The importance of proper and prudent use of antibiotics;						
	Individual staff responsibility for keeping clients/patients/residents, themselves and co-workers safe;						
	Prevention of blood and body fluid exposure; and						
	Education in early problem or symptom recognition.						

PHC ICPs required per Bed - Appendix E									
Table 2: Required ICP FTE based on national standards for Acute and Residential Care facilities									
	Beds	Site Acuity	Standard 1*		Standard 2**		Standard 3***		
			Min	Max	Min	Max	Min	Max	
Acute			3:500	3:500	1:133 (less acuity)	1:100 (high acuity)	1:115 plus	1:115 plus	
			0.006	0.006	0.008	0.010	0.009	0.009	
							0.033	0.033	
Residential			1:250	1:150	1:250	1:250	1:250	1:150	
			0.004	0.007	0.004	0.004	0.004	0.007	
Youville		low							
Acute	0		0.00	0.00	0.00	0.00	0.00	0.00	
Residential	84		0.34	0.56	0.63	0.34	2.80	0.56	
Required FTE to Stds			0.34	0.56	0.63	0.34	2.80	0.56	
ICP FTE Allocation	0.20		0.20	0.20	0.20	0.20	0.20	0.20	
GAP Δ			-0.14	-0.36	-0.43	-0.14	-2.60	-0.36	
St. Paul's		high							
Acute	563		3.38	3.38	0.78	4.59	5.40	6.10	
Residential	12		0.05	0.08	0.05	0.05	0.05	0.08	
Required FTE to Stds			3.43	3.46	0.83	4.64	5.44	6.18	
ICP FTE Allocation	3.21		3.21	3.21	3.21	3.21	3.21	3.21	
GAP Δ			-0.22	-0.25	2.38	-1.43	-2.24	-2.97	
Holy Family		med							
Acute	75		0.45	0.45	0.56	0.30	0.65	0.65	
Residential	142		0.57	0.95	0.57	0.57	0.57	0.95	
Required FTE to Stds			1.02	1.40	1.13	0.87	1.22	1.60	
ICP FTE Allocation	0.78		0.78	0.78	0.78	0.78	0.78	0.78	
GAP Δ			-0.24	-0.62	-0.35	-0.09	-0.44	-0.82	
Brock Fahrni		low							
Acute	0		0.00	0.00	0.00	0.00	0.00	0.00	
Residential	148		0.59	0.99	0.59	0.59	0.59	0.99	
Required FTE to Stds			0.59	0.99	0.59	0.59	0.59	0.99	
ICP FTE Allocation	0.35		0.35	0.35	0.35	0.35	0.35	0.35	
GAP Δ			-0.24	-0.64	-0.24	-0.24	-0.24	-0.64	
Langara		low							
Acute	0		0.00	0.00	0.00	0.00	0.00	0.00	
Residential	221		0.88	1.47	0.88	0.88	0.88	1.47	
Required FTE to Stds			0.88	1.47	0.88	0.88	0.88	1.47	
ICP FTE Allocation	0.52		0.52	0.52	0.52	0.52	0.52	0.52	
GAP Δ			-0.36	-0.95	-0.36	-0.36	-0.36	-0.95	

Mount St. Joseph's Hospital		med						
Acute	124		0.74	0.74	0.14	1.05	1.21	1.21
Residential	100		0.40	0.67	0.40	0.40	0.40	0.67
Required FTE to Stds			1.14	1.41	0.54	1.45	1.61	1.88
ICP FTE Allocation	0.94		0.94	0.94	0.94	0.94	0.94	0.94
GAP Δ			-0.20	-0.47	0.40	-0.51	-0.67	-0.94
TOTAL								
Acute	762		4.57	4.57	1.49	5.94	7.26	7.96
Residential	707		2.83	4.71	3.12	2.83	5.29	4.71
Required FTE to Stds			7.40	9.29	4.61	8.77	12.55	12.67
ICP FTE Allocation	6.00		6.00	6.00	6.00	6.00	6.00	6.00
GAP Δ			-1.40	-3.29	1.39	-2.77	-6.55	-6.67
* Canadian Consensus Panel Recommendations 2001:								
Acute; 3 FTE/500 beds								
LTC; 1 FTE/150-250 bed								
** Quebec Health Recommendation 2005:								
Acute; 1 FTE/100 beds high acuity and 1/133 less acuity								
LTC; 1 FTE/250 beds								
*** Ontario Health Care Facilities Recommendations 2008:								
Acute; 1 FTE/115 beds plus 1 FTE/30 ICU beds								
LTC; 1 FTE/150-200 depending on acuity								
Lower Mainland consensus decision - "Use Quebec guidelines for human resource planning."								

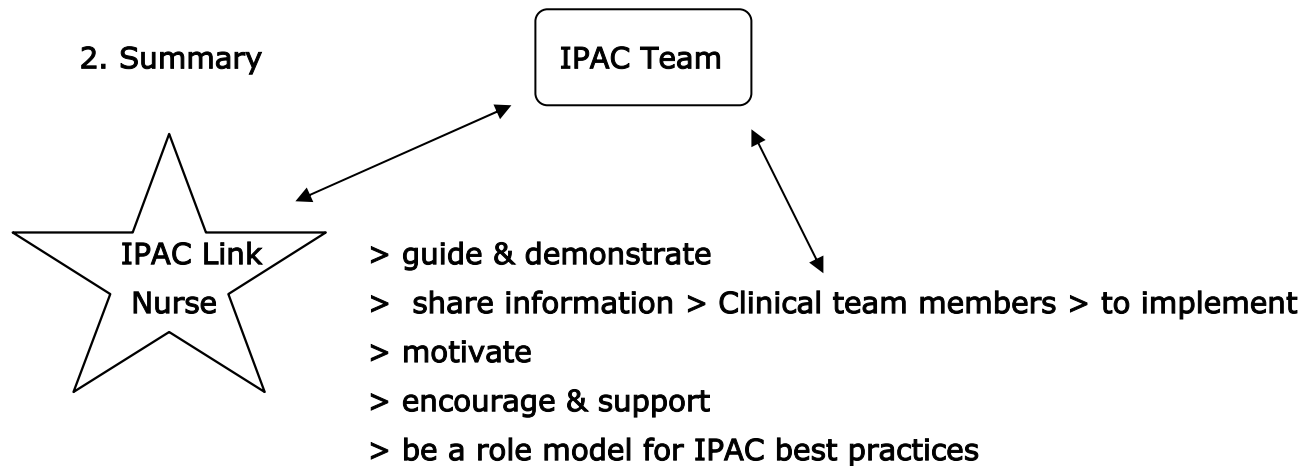
Link Nurse Role

INFECTION PREVENTION & CONTROL (IPAC) LINK NURSE

1. Role

The role of the IPAC Link Nurse is to support other health care providers in their clinical area and to liaise with the Infection Control Practitioner (ICP). With support from the ICP, they are a resource and role model for colleagues. They are not seen as a substitute for an adequately resourced ICP service. The role will be carried out as part of the nurses' regular duties, but protected time will be provided for IPAC Link Nurse responsibilities.

2. Summary



The IPAC Link Nurse will be provided with evidence-based knowledge from the IPAC Department to supplement their:

- communication skills
- nursing and teaching skills
- positive and influencing attitude

3. Background Experience

- 3.1 RN or LPN with at least six months of experience.
- 3.2 An interest in infection prevention and control.

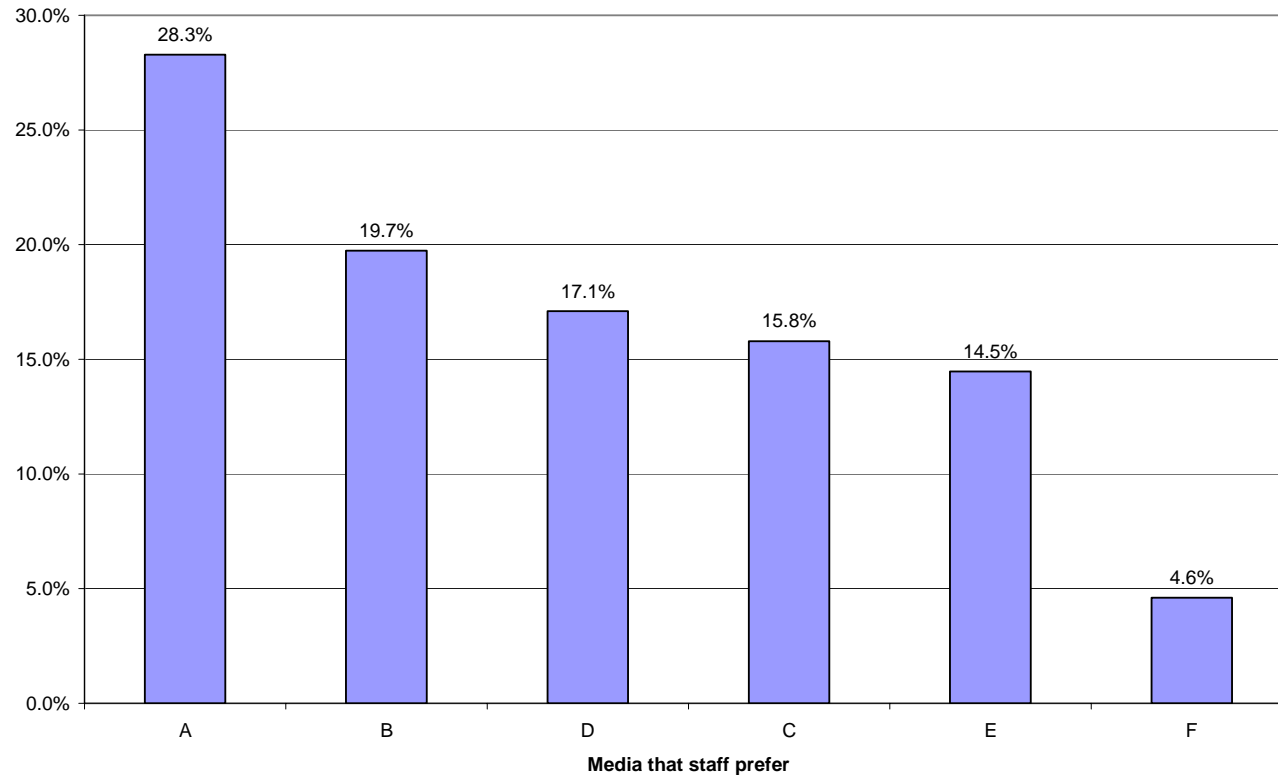
4. Responsibilities

- 4.1 To liaise between their clinical area and the IPAC Team.
- 4.2 To be a support person to help staff & physicians follow IPAC policies and procedures in their clinical area.
- 4.3 The IPAC Link Nurse helps influence change by, providing support & information for staff to improve practice, to comply with standards, and to assist others to respond to surveillance rates & audit results.
- 4.4 To bring to the attention of IPAC any issues with infection prevention and control in their clinical area (e.g. problems with isolation of patients or potential outbreaks).
- 4.5 In conjunction with the ICP, to act as a support person for staff concerning infection control related problems in the clinical area (e.g. outbreaks, isolation, environmental cleaning concerns, etc.)
- 4.6 To assist in the IPAC-related education of staff and patients.
- 4.7 To promote the use of the on-line IPAC Manual.
- 4.8 To assist with the collection of data.

5. Preparation & Professional Responsibilities

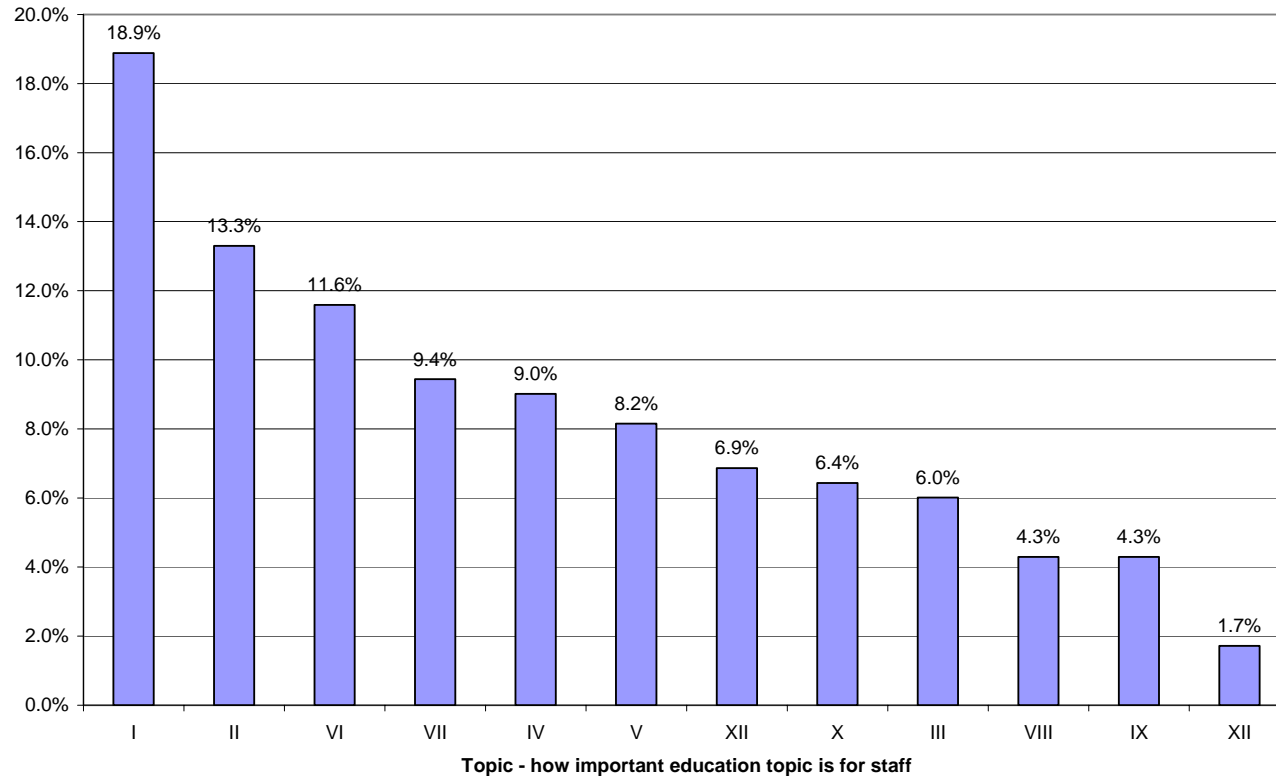
- 5.1 Professional commitment to this role is required
- 5.2 To attend 8 hours of initial IPAC Link Nurse Training
- 5.3 To attend 4 hours of ongoing IPAC Link Nurse Training three times per year (also a networking opportunity with other link nurses)
- 5.4 To dedicate a minimum of 2 hours per week functioning as an IPAC Link Nurse (this time is negotiable and flexible)
- 5.5 To take every opportunity to update and extend his or her knowledge of IPAC.
- 5.6 To include IPAC within their personal development plan.
- 5.7 IPAC Link Nurses who perform well for 1 year, will receive a letter of achievement. A copy of this letter will go on the PHC Human Resource file and contribute to the Nurse's career path.

PHC IPAC EDUC NEEDS SURVEY Jul09



- A short education during huddles on the unit
- B one hour lunch & learn
- C 1 hour scheduled courses
- D Paid Education Program (PEP) days)
- E short interactive e-learning modules on the intranet
- F other

PHC IPAC Educ Needs Survey Jul09



- I Disease transmission, the risks associated with infectious diseases and basic epidemiology of health care-associated infections
- II Benefits of case finding/surveillance and the extent of existing problems (e.g. MRSA, VRE, CDAD)
- III Hand hygiene and basic personal hygiene, including the use of alcohol-based hand rubs and hand washing
- IV Principles and components of standard precautions
- V Principles and components of additional transmission-based precautions
- VI Assessment of the risk of infection transmission and the appropriate use of personal protective equipment (PPE), including safe application, removal and disposal
- VII Appropriate cleaning and/or disinfection of health care equipment, supplies and surfaces or items in the health care environment (e.g. beds, bed tables, call bells, toilets, privacy curtains)
- VIII Aseptic practices
- IX Importance of proper and prudent use of antibiotics
- X Individual staff responsibility for keeping clients/patients/residents, themselves and co-workers safe
- XI Prevention of blood and body fluid exposure
- XII Education in early problem or symptom recognition